Prerenewal Application For:
License #25MD_____(Required)

Podiatrist

State of New Jersey
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

This application is required pursuant to the provisions of N.J.S.A. 45:1-7.1b

➘ **MAILING ADDRESS**

➘ **ADDRESS OF RECORD**

Prerenewal Part I

THIS APPLICATION MUST BE RETURNED BY JUNE 2, 2003. SUBMISSION OF A CURRICULUM VITAE OR RESUME IN LIEU OF COMPLETING THIS APPLICATION WILL NOT MEET THE STATUTORY REQUIREMENT FOR LICENSE RENEWAL. IF YOU DO NOT COMPLETE AND RETURN BOTH PARTS OF THIS PRERENEWAL APPLICATION, YOUR LICENSE RENEWAL APPLICATION WILL NOT BE MAILED TO YOU.

Your podiatry license expires on October 31, 2003. **Your Controlled Dangerous Substance (C.D.S.) registration now expires on February 28, 2004.** As part of the license and C.D.S. registration renewal process, **you must** complete, sign and return both parts of this Prerenewal Application form within 10 days of receipt. Supporting documents may be attached. All documents attached must include your printed name and license number. This Prerenewal Application, with any attachments, must be mailed directly to the Division of Consumer Affairs, P.O. Box 150, Trenton, NJ 08625-0150.

Your license and C.D.S. registration renewal consists of a three-part mailing:

1. Prerenewal Application;
2. License Renewal Application; and
3. C.D.S. Registration Renewal Application (if held).

You must complete and return both parts of the Prerenewal Application and your License Renewal Application before you will receive your renewed license. You must renew your podiatry license in active status in order to be able to renew a C.D.S. registration.

PLEASE PRINT CLEARLY.

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1. You must provide your Social Security number to the Board. Failure to do so will result in nonrenewal.

   ***SOCIAL SECURITY NUMBER** ☐☐☐ - ☐☐ - ☐☐☐☐

   *Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, N.J.S.A. 54:50-25 of the New Jersey taxation law and Section 1128E(b)(2)A of the Social Security Act, the Board is required to obtain your Social Security number. The Board is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or any other agency responsible for child support enforcement, upon request, and to the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions.

2. Pursuant to the Federal Privacy Act (5 U.S.C. Section 55a (note (b)), the Board is requesting your consent to use your Social Security number for the following purposes: 1) to verify identity, 2) to aid in the collection of financial obligations due and owing the Board or any other state agency, and 3) to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure and disciplinary proceedings.

   I ☐ Consent ☐ Do Not Consent to the use of my Social Security number for any of the additional purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

CITIZENSHIP/IMMIGRATION STATUS

3. Federal law limits the issuance or renewal of professional licenses to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the Immigration and Naturalization Service (I.N.S.).

   ☐ U.S. citizen

   ☐ Alien lawfully admitted for permanent residence in U.S.

   ☐ Other immigration status

QUESTIONS ABOUT YOUR IMMIGRATION STATUS AND WHETHER OR NOT IT IS A QUALIFYING STATUS UNDER FEDERAL LAW SHOULD BE DIRECTED TO THE I.N.S. AT: 1-800-375-5283.

MEDICAL MALPRACTICE COVERAGE

By law you must have medical malpractice insurance (in the amount of at least $1 million per occurrence and $3 million per policy year) or a letter of credit (in the amount of at least $500,000) unless you are exempt.

4. Do you have the required medical malpractice coverage or letter of credit? ☐ Yes ☐ No

   If medical malpractice coverage, provide:

   Policy Number: _____ Dates of Coverage: _____

   Name and address of medical malpractice carrier:_____

   _____

   If letter of credit, provide name and address of financial institution:_____

   _____

5. If you do not have the requisite coverage, are you exempt because:

   You are an employee of the federal, state or county government? ☐ Yes ☐ No
   You do not maintain a professional practice, with responsibility for patient care? ☐ Yes ☐ No

6. Since your last renewal, has any malpractice settlement, award or judgment been made against you that you have not already reported to the Board? If "Yes," provide an explanation on a separate sheet. **Include your printed name and license number on any attachment.** ☐ Yes ☐ No

7. Since your last renewal, have you been notified that your malpractice insurance has been denied or canceled (for reasons relating to personal claims history) or has your malpractice insurer required any practice limitations or office monitoring that you have not already reported to the Board? If "Yes," provide an explanation on a separate sheet. **Include your printed name and license number on any attachment.** ☐ Yes ☐ No

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NAME AND ADDRESSES

8. If you have legally changed your name, please print the change on this application next to your printed name, and attach a copy of your marriage certificate, decree of divorce or court order to this application. **Include your printed name and license number on any attachment.** If there is a spelling error, please make the change on this application where your name is printed.

9. **Mailing Address**: **Please complete this section only if it is *different* from the mailing address preprinted on this form.**
   If the mailing address is a P.O. Box, either your home or business address must be a street address. Note: If your mailing address ***has changed or will change by August 1, 2003***, when renewal applications will be printed, please enter your new mailing address below. All mail sent by the Division of Consumer Affairs will be sent to the address you designate as your mailing address.

   RENEWAL APPLICATIONS AND LICENSE CERTIFICATES ARE NOT FORWARDED BY THE POST OFFICE.

   Street address | Apartment/Floor number

   City | State | ZIP Code

10. **Home Address**:

    Street address

    City | State | ZIP Code

    Home telephone number (including area code) | E-mail

    Is this phone number unlisted? ☐ Yes ☐ No

11. **Business Address:**

    Practice name | Suite or room number

Street address

City | State | ZIP Code

Business telephone number (including area code) | E-mail

12. **Other Business Address:**

Practice name | Suite or room number

Street address

City | State | ZIP Code

Business telephone number (including area code) | E-mail

13. **Address of Record: Your address of record is printed on the front of this form. If it is not correct, indicate below which address is your address of record.** (Check ***only one*** box below.) If you do not indicate an address of record, your mailing address will be considered your address of record. Your address of record is printed on your license and may be made available to the public. **An address of record may be a post office box, but only if another address with a street, city, state and ZIP code is provided.**

☐ Mailing ☐ Home ☐ Business

(If you have listed more than one business address, specify which one will be your address of record by circling the number above.)

OTHER LICENSURE AND PRIVILEGE INFORMATION

14. Questions (a) and (b) below refer to matters that you have not already reported to the Board.

(a) Since November 1, 1999, has any action been taken, or have you been notified of any action pending, against your privileges at or membership rights in any of the entities listed below? ☐ Yes ☐ No

(b) Since November 1, 1999, have you, while under investigation, resigned, surrendered or relinquished your privileges at or membership rights in any of the entities listed below? ☐ Yes ☐ No

If you answered "Yes," to either of the above questions, check the appropriate box(es) below and attach an explanation on a separate sheet. Include your printed name and license number on any attachment(s).

☐ Federal Drug Enforcement Agency	☐ State Drug Enforcement Agency	☐ U.S. Department of Health & Human Services
☐ Medicaid	☐ Medicare	☐ Professional Review Organization (PRO)
☐ Any branch of the U.S. Armed Forces	☐ Any HMO or managed care entity	☐ Any health care facility
☐ Non-Federal Utilization Review Organization	☐ Any licensing jurisdiction	☐ Any hospital

15. List all states in which you hold a license to practice podiatry (include state, license number and the license status: active or inactive). If additional space is needed, attach a sheet listing the required information. **Include your printed name and license number on any attachment.**

State	License number	Active/Inactive Circle Status

State	License number	Active/Inactive Circle Status

ASSOCIATIONS, AFFILIATIONS AND FINANCIAL INTERESTS

16. If you provide services at any professional practices, other than those listed by name in this form, provide the name and address of those practices. If these practices do not have names, you must list the name, practice address and license number of every physician or podiatrist with whom you are associated in these practices. If additional space is required, attach a sheet (or practice letterhead) listing the required information. **Include your printed name and license number on any attachment.**

_____

Name of Practice/Physician or Podiatrist | Address | License number

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Name of Practice/Physician or Podiatrist | Address | License number

17. Please provide the names of any hospitals or health care facilities with which you are currently affiliated, or at which you are on staff or hold privileges. If additional space is needed, attach a sheet listing the required information. **Include your printed name and license number on any attachment.** If you are not affiliated with any hospital or healthcare facility write NA on the first line.

_____

Name | Address | Nature of Affiliation

_____

Name | Address | Nature of Affiliation

_____

Name | Address | Nature of Affiliation

18. Check all of the HMOs in which you are a participating provider.

- ☐ Aetna Health, Inc.
- ☐ AmeriHealth HMO
- ☐ Coventry Health Care of Delaware, Inc.
- ☐ Horizon HealthCare Plan of New Jersey
- ☐ United Health Care of New Jersey, Inc.
- ☐ AmeriChoice of New Jersey, Inc.
- ☐ AtlantiCare Health Plans, Inc.
- ☐ Empire HealthChoice HMO, Inc.
- ☐ One Health Plan of New Jersey, Inc.
- ☐ University Health Plans, Inc.
- ☐ Amerigroup New Jersey
- ☐ Cigna HealthCare of New Jersey, Inc.
- ☐ Health Net of New Jersey, Inc.
- ☐ Oxford Health Plans, Inc.
- ☐ Other-Specify:_____

19. Do you or members of your immediate family own any financial interest in any health care related business entities (other than your primary practice or any publicly traded stocks)? ☐ Yes ☐ No If "Yes," answer the questions below. If additional space is needed, attach a sheet listing the required information. **Include your printed name and license number on any attachment.**

_____

Entity | Address | Date Acquired

Do you refer patients to the entity above? ☐ Yes ☐ No

_____

Entity | Address | Date Acquired

Do you refer patients to the entity above? ☐ Yes ☐ No

SPECIALTIES AND BOARD CERTIFICATION

20. List specialties and subspecialties; if you are Board Certified, provide the name of the certifying entity.

_____ Certifiying entity, if applicable: _____

_____ Certifiying entity, if applicable: _____

_____ Certifiying entity, if applicable: _____

CERTIFICATION AND SIGNATURE (You must sign both parts of the Prerenewal Application.)

"I certify that the information entered on this application is true and complete to the best of my knowledge, and further acknowledge that if the information supplied on this application is willfully false, I am subject to punishment and/or disciplinary sanction including suspension/ revocation of licensure or the imposition of civil penalties as may be provided by law."

_____ _____

Signature of Licensee | Date

As a condition of licensure, you are required to notify the State Board of Medical Examiners, in writing, within 21 days, of any subsequent changes to the information reported on this Prerenewal Application.

State of New Jersey
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

Prerenewal Part II

(This form is two-sided.)

➘ **Name** ➘ **License Number**

This form must be returned with Part I of the Prerenewal Application. If you fail to return this part (Part II) of the Prerenewal Application, your renewal application will not be sent to you.

MEDICAL CONDITIONS/CHEMICAL SUBSTANCES

The questions below pertain to physiological, medical or psychological conditions and the use of chemical substances. Your responses will be treated confidentially and separately retained by the Board. If you answer "Yes" to either question below, your application will continue to be processed and the Board will contact you to obtain additional information.

*Note: If you have a good faith reason to believe that answering the questions may expose you to possible criminal prosecution, you may assert the Fifth Amendment privilege against self-incrimination. If you do so, your renewal application will still be processed. However, you may later be directed by the Attorney General to answer these questions, provided that the Attorney General first grants you immunity afforded by statutory law pursuant to N.J.S.A. 45:1-20.

☐ I am claiming my Fifth Amendment Privilege

As you review the questions, keep the following definitions in mind:

"Ability to practice podiatry" is to be construed to mean the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments.

2. The ability to communicate those judgments and medical information to patients and to other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Alternative Resolution Program ("A.R.P.")" refers to the program established pursuant to N.J.A.C. 13:35-11 et seq. by which licensees suffering from impairments may confidentially enter into a rehabilitation and monitoring program, under the sponsorship of an approved professional assistance program, subject to periodic submission of coded status reports and continuing confidential review by the Board's Impairment Review Committee ("I.R.C."). To be considered a participant in the A.R.P., you must be accepted by the I.R.C. and assigned a code number.

1. Do you have any condition or engage in any activity, or use any substance (including alcohol, drugs or medications) which affects, impairs or limits your ability to practice medicine with reasonable skill and safety, not already known to the I.R.C. through your participation in the A.R.P.? ☐ Yes ☐ No

2. Have you, since November 1, 2001, used any controlled dangerous substances (other than those used as authorized by a valid prescription issued by another healthcare provider), not already known to the I.R.C. through your participation in the A.R.P.? ☐ Yes ☐ No

"I certify that the answers given are true and complete to the best of my knowledge, and further acknowledge that if my answers are willfully false, I am subject to punishment and/or disciplinary sanction including suspension/revocation or the imposition of civil penalties as may be provided by law."

_____ _____

Signature of Licensee Date

INFORMATION CONCERNING FUTURE BOARD INITIATIVES

SURGERY AND ANESTHESIA IN THE OFFICE SETTING

On December 16, 2002, N.J.A.C. 13:35-4A.12 became effective. By December 16, 2003, podiatrists who do not hold hospital privileges to perform surgery or special procedures or to administer or monitor the administration of anesthesia services, but provide these services in an office setting, must apply to the Board for alternative privileges. The following questions are designed to assist in the implementation of this process.

1. Do you do the following in an office setting (not a hospital or licensed surgicenter)?

a. Perform any surgery or special procedures with general or regional anesthesia or conscious sedation?	a. ☐ Yes ☐ No
b. Administer and/or monitor the administration of general or regional anesthesia?	b. ☐ Yes ☐ No
c. Administer and/or monitor the administration of conscious sedation?	c. ☐ Yes ☐ No

2. Do you have privileges granted by a licensed hospital to:

a. Perform the same surgery or special procedures with general or regional anesthesia or conscious sedation that you perform in your office?	a. ☐ Yes ☐ No
b. Administer and/or monitor the administration of general or regional anesthesia?	b. ☐ Yes ☐ No
c. Administer and/or monitor the administration of conscious sedation?	c. ☐ Yes ☐ No

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IMPORTANT INFORMATION REGARDING CONTINUING EDUCATION REQUIREMENTS FOR THE 2003-2005 RENEWAL PERIOD

Continuing Medical Education ("CME") Requirements: A new law was passed in January 2002 which requires continuing medical education requirements as a condition for renewal of a license. In short, a licensee is required to complete 100 credits of CME, all of which must be in Category I or Category II as recognized by the American Medical Association as credited toward the Physician Recognition Award, the American Osteopathic Association, the American Podiatric Medical Association or other comparable organizations recognized by the Board. Forty of the 100 credits must be in Category I. **Regulations are in the process of being drafted.** This information is for planning purposes. **During the renewal period of November 1, 2003 through October 30, 2005, licensees are required to complete 50 CME credits, 20 of which must be in Category I.** For each subsequent renewal period, 100 credits must be completed within the two-year period. At the time of renewal in 2005, a licensee will be required to certify on the renewal application that (s)he has completed the required number of credits. The Board may conduct random audits to determine compliance. A licensee is required to maintain all evidence of verification of credits for a minimum of six years and submit such documentation to the Board upon request. These requirements do not apply to those who hold an inactive or retired license; however, if reinstatement is sought, 50 credits for each year out of practice will be required prior to restoration.